No. 81-5629

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

Rosier Jennings b/n/f; Kathleen Jennings; Hershel Choate; Wilma Ann Hyder; Clyde Vaughn b/n/f; Edith Vaughn; Paul Ramone Parsons b/n/f; Lou Ann Bradley; Rebecca West b/n/f; Paulette West; Michaelle Ogle b/n/f; Lind Sue Ogle; Eldon Kerr; Stella Karris; Sadie I. Owens; Margaret Betty; Charles Baldwin; Carrie Clemons,

Plaintiffs-Appellants,

v.

Lamar Alexander; Eugene Fowinkle; Ben Crim; Carolyn Hale,

Defendants-Appellees.

On Appeal from the United States District Court for the Middle District of Tenessee.

Decided and Filed August 4, 1983

Before: Keith, Merritt, and Jones, Circuit Judges.

Keith, Circuit Judge, delivered the opinion of the Court, in which Jones, Circuit Judge, joined. Merritt, Circuit Judge, (pp. 20-26) filed a separate dissenting opinion.

Keith, Circuit Judge. Appellants, Medicaid recipients from the State of Tennessee, challenge the State's attempt to restructure its Medicaid Plan. Appellants contend that Tennessee's

proposed reduction in the number of hospital days covered by Medicaid from twenty to fourteen per annum violates Section 504 of the Rehabilitation Act, 29 U.S.C. §794 and Section 1396(a)(19) of the Medicaid Act, 42 U.S.C. §1396a(a)(19). They also argue that any reduction must be approved by the Secretary of Health and Human Services. After a bench trial, the district court dismissed each of Appellants' claims. For the reasons set forth below, we vacate the district court's order and remand this case for further consideration not inconsistent with this opinion.

This action was originally brought in the United States District Court for the Middle District of Tennessee on behalf of all the State's Medicaid recipients. It challenged an array of proposed reductions by the State designed to save money on the State's share of Medicaid expenditures.[1] The proposed reductions included, *inter alia,* deletion of certain drugs from the Medicaid formulary, reductions in the level of reimbursement for health care providers, reduction of inpatient hospitalization coverage, and reduction of outpatient hospitalization services. Appellants also sought to enjoin the proposed reductions because they had not been approved by a valid Medicaid Medical Care Advisory Committee as prescribed by federal regulations. 42 C.F.R. §431.12.

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[1] Medicaid is a voluntary undertaking by a state. The Federal government places no ceiling on funds to a state program, but federal funds are contingent upon matching funds by the state. Although the program is voluntary, once a state decides to participate, it must do so in conformity with the requirements of Title XIX of the Social Security Act of 1965 and applicable regulations. *Harris* v. *McRae,* 448 U.S. 297, 301 (1980).

The State of Tennessee provides approximately thirty state dollars for each seventy dollars the federal government contributes. For fiscal year 1980-81, the Tennessee General Assembly "appropriated state dollars which, when matched with federal funds, constituted a budget of $388,000,000." This figure represented a $26,000,000 increase over the State's Medicaid budget for the preceding year.

On September 3, 1980, the district court enjoined the State's promulgation of the proposed reductions until a validly constituted Medical Care Advisory Committee had reviewed them. On December 12, 1980, the State petitioned the district court to set aside the preliminary injunction. The State argued that a properly constituted committee had not acted after having sufficient time to do so. The court did not rule on this motion.

By the time of the March 13, 1981 bench trial, the validity of only two proposed reductions were at issue: the deletion of certain drugs from the Medicaid formulary and the reduction in the number of inpatient days for which Medicaid would pay. Prior to the district court's opinion on June 17, 1981, the parties settled the former issue. Only the validity of the State's reduction in hospitalization coverage remained to be resolved by the court.

In its opinion, the district court held (1) that the proposed reduction did not violate Section 504 of the Rehabilitation Act of 1973, (2) that the proposed reduction was not inconsistent with the best interests of the recipients in contravention of 42 U.S.C. §1396(a)(19), and (3) approval from the Secretary of Health and Human Services was not needed to implement the changes. However, the court found that the State had failed to comply with the procedures outlined in 42 C.F.R. § 447.205 which establish guidelines for providing public notice of proposed changes. Therefore, the court refused to set aside its September 3, 1980 preliminary injunction.

I.

The initial question for review is whether the district court erred in holding that the proposed reduction from twenty to fourteen days per annum does not violate Section 504. The district court held that the appellants had not made a showing of discrimination against the handicapped becasue there had been no showing of disparate impact upon handicapped persons. Furthermore, the court held that even if Appellants had

proved disparate impact, the disparate impact was not discrimination against the handicapped as contemplated by the Rehabilitation Act of 1973. We disagree.

A.

29 U.S.C. §794 provides in relevant part:

> No otherwise qualified handicapped individual in the United States, as defined in section 706(7) of this title, shall, solely by reason of of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.[2]

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[2] Handicapped individual as defined at 29 U.S.C. 706(7):

(7) (A) Except as otherwise provided in subparagraph (B), the term "handicapped individual" means any individual who (i) has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and (ii) can erasonably be expected to benefit in terms of employability from vocational rehabilitation services provided pursuant to subchapters I and III of this chapter.

(B) Subject to the second sentence of this subparagraph, the term "handicapped individual" means, for purposes of subchapters IV and V of this chapter, any person who (i) has a physical or mental impairment which substantially limits one or more of such persons's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment. For purposes of sections 793 and 794 of this title as such sections relate to employment, such term does not include any individual who is an alcoholic or drug abuser whose current use of alcohol or drugs prevents such individual from performing the duties of the job in question or whose employment, by reason of such current alcohol or drug abuse, would constitute a direct threat to property or the safety of others.

The courts which have considered the issue have uniformly held that Section 504 creates a private cause of action for those who are its intended beneficiaries. *See infra* note 4 and accompanying text. Although the Supreme Court did not address this issue in *Southeastern Community College* v. *Davis*, 442 U.S. 397 (1981), its actions in several cases suggest that the Court has assumed that a private cuase of action exists in Section 504 cases. *ID.*[3].

Though a thorough examination of this issue has already been provided by several circuit courts, we note our agreement that sound judicial analysis supports implying a private cause of action for injunctive relief. In its discussion of the Technical and Clarifying Amendments to the Rehabilitation Act, the Senate Report explained:

> Section 504 was patterned after and is almost identical to, the antidiscrimination language of section 601 of the Civil Rights Act of 1964, 42 U.S.C. 2000d-1 (relating to race, color, or national origin) and section 901 of the Education Amendments of 1972, 42 U.S.C. 1683 (relating to sex). The section therefore constitutes the establishment of a broad government policy that programs receiving Federal financial assistance shall be operated without discrimination on the basis of handicap. It does not

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For purposes of this case, statistics relating to handicapped recipients include "only those recipients whose Medicaid eligibility is based on blindness or disability." All recipients over sixty-five (65) are classified as aged whether or not they are blind or disabled. Furthermore, "[o]f those recipients of inpatient services who have only Medicaid (no Medicare) coverage, 1,833 are 'aged.'" Since the parties could not agree on how many of these recipients were handicapped, they are all reflected in the statistics as non-handicapped.

[3]. *See, e.g., Campbell* v. *Kruse*, 434 U.S. 808 (1977), where the Supreme Court vacated the district court's order and remanded the case for a decision based on Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794.

specifically require the issuance of regulations or expressly provide for enforcement procedures, but it is clearly mandatory in form, and such regulations and enforcement are intended.

The language of Section 504, in following the above-cited Acts, further envisions the implementation of a compliance program which is similar to those Acts, including promulgation of regulations providing for investigation and review of recipients of Federal financial assistance, attempts to bring non-complying recipients into voluntary compliance through informal efforts such as negotiation, and the imposition of sanctions against recipients who continue to discriminate against otherwise qualified handicapped persons on the basis of handicap. Such sanctions would include, where appropriate, the termination of Federal financial assistance to the recipient or other means otherwise authorized by law. Implementation of section 504 would also include pregrant analysis of recipients to ensure that Federal funds are not initially provided to those who discriminate against handicapped individuals. Such analysis would include pre-grant review procedures and a requirement for assurances of compliance with section 504. This approach to implementation of section 504, which closely follows the models of the above-cited anti-discrimination provsions, would ensure administrative due process (right to hearing, right to review), provide for administrative consistency within the Federal government as well as relative ease of implementation, and permit a judicial remedy through a private.

S. Rep. No. 1297, 93d Cong., 2d Sess. 6390-91, *reprinted in* 1974 U.S. Code Cong. & Ad. News 6373.

The guidelines enunciated in *Cort v. Ash*, 422 U.S. 66 (1975) for implying a private cause for action are clearly met. First, Section 504 was enacted for the special benefit of handicapped

persons as defined in the Rehabilitation Act. Second, there is express language in the legislative history which supports a congressional intent to imply a private cause of action. Third, the structure and underlying purpose of the Act is consistent with the implication of a private judicial remedy. Finally, the cause of action is not one generally relegated to the states and inappropriate for federal law. We, therefore, agree with the other circuits that have considered the issue and hold that Section 504 creates a private cause of action for its intended beneficiaries.[4]

B.

Section 504 is "part of the general corpus of discrimination law." *New York State Association for Retarded Children* v. *Carey*, 612 F.2d 644 (2d Cir. 1979). It is predicated on Title VI of the Civil Rights Act, 42 U.S.C. §2000d, and is intended to prohibit the expenditure of public funds in programs that discriminate against the handicapped. *See* Sen. Rep. 1297, *supra*. Courts have generally applied the same tests of discrimination law to Section 504 as are applied to Title VI.

In *N.A.A.C.P.* v. *The Medical Center, Inc.*, 657 F.2d 1322 (3d Cir. 1981), (*en banc*), the Third Circuit exhaustively considered the evidence needed to prove a prima facie violation of Title VI. Having concluded that Title VI requires only that a

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[4] *See Leary* v. *Crapsey*, 566 F.2d 863 (2d Cir. 1977) *(per Curiam); N.A.A.C.P.* v. *The Medical Center, Inc.*, 599 F.2d 1247 (3d Cir. 1979), *aff'd.*, 657 F.2d 1322 (3d Cir. 1981) (*en banc*); *Davis* v. *Southeastern Community College*, 574 F.2d 1158 (4th Cir. 1978), *rev'd on other grounds*, 442 U.S. 397 (1979); *Camenisch* v. *University of Texas*, 616 F.2d 127 (5th Cir. 1980), *cert. granted*, 449 U.S. 950, *vacated*. 451 U.S. 390 (1981); *Lloyd* v. *Regional Transportation Authority*, 548 F.2d 1277 (7th Cir. 1977); *United Handicapped Federation* v. *Andre*, 558 F.2d 413 (8th Cir. 1977); *Kling* v. *County of Los Angeles*, 633 F.2d 876 (9th Cir. 1980); *Puskin* v. *Regents of the University of Colorado*, 658 F.2d 1372 (10th Cir. 1981); *Prewitt* v. *United States Postal Service*, 662 F.2d 292 (11th Cir. 1981) (former Fifth Circuit opinion).

plaintiff prove disparate impact in the application of federal funds, the court concluded, "The Rehabilitation Act and the Age Discrimination Act of 1975 provide equally strong cases for application of an impact test since both are patterned after Title VI." *ID.* at 1331. *See also Bryan* v. *Koch,* 627 F.2d 612, 621 (2d Cir. 1980).

Both *Bryan* and *The Medical Center* involved the use of federal funds by a state or municipal government to implement a facially neutral policy which affected certain protected groups more harshly than others. As Judge Kearse noted in *Bryan,* the regulatory agencies responsible for effectuating Title VI-type statutes have applied "a broad 'disparate impact,' or 'effects,' test." (Separate Opinion of Judge Kearse at 621). Indeed, the regulations promulgated under Section 504 specifically forbid the use of federal funds for programs which have discriminatory effects against the handicapped.[3] Regulations by the enforcing agency are entitled to great weight. *Brennan* v. *Owensboro-Davies County Hospital,* 523 F.2d 1013, 1028 (6th Cir. 1975), *cert. denied,* 425 U.S. 973 (1976).

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[3] 45 C.F.R. 84.4 (1981) provides in relevant part:

> §84.4 Discrimination prohibited.
>
> (a) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.
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> • • •
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> (4) A recipient may not, directly or through contractual or other arrangements, utilize criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same State.

The district court acknowledged authority for applying an effects test in this case. It then proceeded to distinguish cases applying on effects test, most notably the district court opinion in *The Medical Center.*[4] The district court concluded that *The Medical Center* was not applicable. We disagree.

The factual distinction between this case and *The Medical Center* is not analytically significant for purposes of determining what constitutes a prima facie case. *The Medical Center* involved the relocation of a hospital from an inner-city location to a suburban site. This was challenged as having an adverse effect upon minorities and the aged as well as the handicapped. The district court concluded that an effects test should be applied. After extensive litigation, the Third Circuit, sitting *en banc,* affirmed the application of an adverse effects test, but found that the plaintiff had not produced enough evidence to prove a prima facie case. *See also Prewitt v. United States Postal Service,* 662 F.2d 292 (5th Cir. 1981) (application of a discriminatory impact test when federal government is the employer in handicapped discrimination case); *Bryan* v. *Koch,* 627 F.2d 612 (2d Cir. 1980) (expressing no view on issue, the court assumed disparate impact test to be appropriate but found city had met its burden of rebuttal).

We think the district court erred by confusing the prima facie case with a decision on the ultimate outcome. The district court, seeking to minimize the importance of the *The Medical Center* district court, opined:

> Thus, it is far from clear that the *The Medical Center* court intended to adopt as strict an "impact test" as the plaintiffs contend. Rather, it would appear that the court recognized that a program need not be equally productive

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[4] The district court opinion in this case was rendered before the Third Circuit's panel and *en banc* opinions in *N.A.A.C.P.* v. *The Medical Center.*

> for handicapped and non-handicapped alike, as long as the program is equally accessible to both groups.

518 F.Supp. 877 (M.D. Tenn. 1981). But the appellate opinions in *The Medical Center* hold that the establishment of a prima facie case is merely a prelude to the court's assessment of whether the alternative chosen is discriminatory against the handicapped. The establishment of disparate imapct is not determinative of whether the defendant is guilty of discrimination. It merely requires the defendant to rebut the inference of discriminatory action. We therefore hold that the showing of disparate impact proved a prima facie case and required the state to explain its choice.

C.

Alternatively, the district court held that even if discriminatory impact had been shown, the plaintiffs had failed to prove a prima facie case. The court reasoned:

> For example, there was no attempt to show what percentage of handicapped users required inpatient hospital treatment as a result of their handicapping condition. It seems likely that some handicaps, such as blindness, would rarely require hospitalization, while others, such as mental illness, might well require frequent hospitalization. Without some such evidence, the court is left to speculate on what extent the existence of handicaps in the broad sense of §504 affects the statistical disparity shown for the study year. Indeed, the actual impact of the proposed limitation, even in the study year, should be kept in perspective. Since only 18.586% of handicapped eligibles used any inpatient hospital services, and 27.4% of those needed more than 14 days of hospital treatment. Thus, 95% would have been fully served at 14 days.

518 F.Supp. at 883 n.6. Again, we disagree. We agree with the district court that the statistical evidence was not perfect. But

we also note that since a significant number of Medicaid recipients have been omitted from the statistics, it is much more likely that the numbers understate the disparity between handicapped and non-handicapped Medicaid users.[7]

Furthermore, the district court's statement that no evidence was presented which would suggest that the disparity would continue is clearly erroneous. Along with their statistical evidence, the plaintiffs presented medical testimony which described the inpatient hospitalization pattern of patients with certain handicaps. For example, Dr. Samuel Marney, who specializes in the treatment of pulmonary ailments, testified upon deposition that patients suffering from asthma, emphysema, chronic bronchitis, or other obstructive lung diseases often "require longer hospitalization for intensive therapy than fourteen days." Dr. Georgia Montouris, a neurologist, testified upon deposition that, "Degenerative diseases of neurology often require hospitalizations." She further testified that fourteen days a year would not adequately take care of such patients' needs. Dr. Joseph Stinson stated in his deposition that in his experience the average asthma patient requires hospitalization four to five times a year with an average stay of ten to fourteen days. Dr. Gordon Turner, a surgeon, testified upon deposition that limitations on the number of days rather than number of admissions often caused handicapped persons to delay surgery until minor surgery became major surgery.

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[7] *See supra* note 2. We also note that the State concedes that its proposed reductions have a disparate impact on the handicapped. The State's appellate brief admits:

> The statistics and studies were compted and analyzed by the parties in several different ways during the course of the trial. Suffice it to say, the studies indicated that the handicapped population of Medicaid recipients would suffer proportionally more from the reduction in hospital benefits than the non-handicapped Medicaid recipients.

Even if we were not persuaded by the bare statistical evidence, the opinions of these medical experts along with other expert testimony wuld convince us that the plaintiffs presented a prima facie violation of Section 504. The medical evidence buttresses the position that these statistics are probative of discrimination against the handicapped.[8]

D.

Having found a prima facie violation of Section 504, we now find it appropriate to consider the justification offered by the State for adopting the fourteen day inpatient maximum. We consider this justification along with the plaintiff's contention that an alternative was available which would save the State the same amount of money and have a less discriminatory effect on the handicapped.

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[8] The dissenting opinion argues that this case is more analogous to *Doe* v. *Colautti*, 592 F.2d 704 (3d Cir. 1979) and other cases which discuss physical access to facilities. The dissent appears to agree with the district court that "physical access" is all that section 504 requires. Yet such a wooden notion of access is clearly not what was intended by the enactment of section 504. Rather, "access" must be read in terms of the goals fo the Act. 45 C.F.R. §84.4(b)(2) requires that the handicapped be given an equal opportunity to succeed at the goal of the program. Further, 45 C.F.R. §84.4(b)(4) states that the program must be run in a manner that does not impair the objectives of the plan. Though not every inequality in the number of days provided to handicapped and non-handicapped persons constitutes discrimination against the handicapped, it certainly would be too simplistic an analysis to hold that all the Medicaid program requires is a particular number of days in the hospital. Rather, it is likely that the objective is to afford the best cure, therapy, or preventative treatment that the allotted funds can provide. This is made clear by the Tennessee law defining medical assistance as the "payment of the cost of care, services and supplies necessary to prevent, diagnose, correct or cure conditions in the person." Tenn. Code Ann. §14-23.103(2). The disparate impact shown here, we conclude, shows the kind of inequality sought to be prevented by section 504.

We begin our analysis with an acknowledgement that the State has a great deal of latitude in structuring the services it provides to its citizens. But it may not use federal funds in a program which discriminates against a racial group (Title VI), a particular sex (Title IX), or individuals with handicaps (Section 504). Moreover, we agree with the court's opinion in *New York State Association For Retarded Children v. Carey* at 650:

> Requiring governmental agencies to rebut in court a prima facie case of discrimination against the handicapped does not mean that the expertise of responsible administrators is to be denigrated. When the validity of challenged governmental action turns on an assessment of technical matters foreign to the experience of most courts, it may be entirely appropriate to resolve closely contested disputes in favor of the responsible administrators.

The State clearly proved that is was justified in attempting to reduce its Medicaid expenses. "No one would contest that the [State] must assign priorities among competing economic demands and evaluate political and economic alternatives. *Bryan* at 621 (Separate Opinion of Judge Kearse). The evidence presented showed that the Medicaid program would have required $42,000,000 additional dollars to maintain the same level of services during fiscal year 1980-81 as were provided in fiscal year 1979-80. Since the State of Tennessee is prohibited by statute from deficit spending in its Medicaid program, it must provide services within the means granted by its General Assembly. The plaintiffs do not dispute this, and this court accepts these parameters.

But the plaintiffs contend that the State could achieve the same level of savings by an alternative method. They argue that the State could achieve the desired level of savings by limiting the total number of visits per annum rather than the number of days. According to plaintiffs, this alternative is preferable because the handicapped would not be deterred from going to

the hospital earlier. Thus, the illness could be diagnosed and treated at an earlier stage, decreasing the need for long periods of hospitalization. Moreover, testimony was presented that, in individual cases, hospitals are not likely to eject Medicaid patients who exhaust their Medicaid days while in the hospital. But many hospitals will refuse entrance to sick persons who have no Medicaid days left. Dr. Marney, Dr. Turner, and Dr. Stein all indicated in their testimony that it would be better for the patients to have a system where they could come to the hospital on numerous occasions than to have a fixed number of days.

On the other hand, the State produced no evidence to rebut the plaintiff's claim. Rather, the evidence indicated that the State only considered two alternatives. The first was a change in the reimbursement method for health care providers. This was hastily withdrawn when the providers protested and it was learned that such a change would require approval from the Department of Health, Education and Welfare. A reduction in the services provided to Medicaid patients was instituted in its place. The testimony of Mr. James E. Word, Deputy Commissioner of Public Health, indicated that no attention was given to the discriminatory impact this might have on the handicapped or any group.

Federal courts are not empowered to substitute their judgments for that of State officials charged with administrative fact finding and decision making have to do with the state. *New York State Association for Retarded Children* v. *Carey,* 612 F.2d at 648; *Bryan* v. *Koch,* 627 F. 2d at 619; *The Medical Center,* 657 F.2d at 1338.

> However, the courts are...assigned a sensitive task, and that task is to ensure that the established legal standards — constitutional and statutory — are followed by government agencies. To permit the factual determinations of these agencies to go unchallenged may be to neglect this task, for the facts will often be dispositive, and the ques-

> tion of compliance with legal standards will often be determined by the manner in which the agency has found the facts.

Carey, F.2d at 648.

In this case, the plaintiffs proved a prima facie case of discrimination against the handicapped *and* purported to present an alternative which had a less discriminatory impact and would meet the State's need to save money. When a recipient of federal funds uses the money in a manner which has disparate impact, Section 504 requires, at the least, that the State show that its decision-making process was a rational one. *Bryan* v. *Koch,* 627 F.2d at 621 (Separate Opinion of Judge Kearse) (in the context of Title VI and racial discrimination).

This is not an onerous burden. It merely requires the recipient to present some evidence that its decision is the product of lawful process which complies with minimum statutory standards. Courts are not free to ignore claims of discrimination merely because they are against a state. As the Second Circuit has noted:

> Clearly, deference to a state agency's fact finding is inappropriate once that agency is the defendant in a discrimination suit. The agency is required to come forward in the district court with sufficient evidence to rebut the plaintiff's *prima facie* case (footnote omitted).

Carey, 612 F.2d at 649.[9]

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[9] Our antidiscrimination analysis is similar to that employed in *N.A.A.C.P.* v. *The Medical Center, Inc.,* 657 F.2d 1322 (3d Cir. 1981) (*en banc*) and *Bryan* v. *Koch* 627 F.2d 612 (2d Cir. 1980). In *Wilmington Medical Center,* the court found that the defendant had justified its decision to relocate an inner city hospital to a suburban site although the relocation adversely affected certain protected groups. The court affirmed the district court which required the defendant to prove that it had chosen the least discriminatory site.

Because the State failed to present any evidence to rebut the plaintiff's prima facie case, we must remand. Plaintiffs have established a prima facie case of discrimination against the handicapped. The State now has the burden of coming forward with some substantial justification for the adoption of the plan with the greater discriminatory impact. Or the State may demonstrate that the alternative method offered by Appellants will not accomplish the State's objective of cost-saving.[10]

II.

Appellants also maintain that the State's decision is contrary to the best interests of Tennessee Medicaid recipients. Thus, it is

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In *Bryan*, the court refused to require the defendant to consider alternative sites. But in its discussion of this issue, the court cautioned, "We do not foreclose the possibility of a situation where some arrangement, other than the closing of a facility, has such obvious advantages that it must be considered as an alternative to a closing with a significant disproportionate impact." *Id.* at 619. We think that an alternative plan which promises to provide better health service at comparable costs is of such importance that it must at least be considered by the state when the proposed plan would adversely affect the health care of handicapped persons.

[10] We are at a loss to explain the statement in the dissenting opinion which argues that this analysis "creates a whole new source of challenges to state budgetary decisions" We merely interpret a congressional enactment which requires that participant-states consider the impact of changes in their Medicaid program on certain identifiable groups. These groups include racial groups and the elderly as well as the handicapped. The State, by its own admission, failed to consider the impact of the proposed reductions on any group.

While one might disagree with the congressional decision to include the handicapped in its set of protected individuals, our obligations is to strike a balance between the rights conferred upon the handicapped by Congress and the State's right to structure its Medicaid program as it Chooses *as long as that choice is non-discriminatory.*

contended, the reduction violates section 1396a(a)(19) of the Medicaid Act, 42 U.S.C. §1396a(1)(19).[11]

The only authority cited by appellants is *Budnicki* v. *Beal,* 450 F.Supp. 546 (E.D. Pa. 1978). In *Budnicki,* the court held than an alteration in a state's Medicaid program will meet 1396a(a)(19)'s standards if it is "not irrational, or arbitrary and counterproductive to the medical well-being of all Medicaid recipients." *Id.* at 557. *Accord Philadelphia Welfare Rights Organization* v. *O'Bannon,* 517 F.Supp. 501, 508 (E.D. Pa. 1981) aff'd, 681 F. 2d 808 3rd Cir. 1982).

Assuming that this is the correct standard, there is no basis foı finding the state's proposed reductions to be arbitrary or counterprductive to the interests of al lMedicaid recipients. If the fourteen day per annum limitation is implemented, ninety-five percent of all Medicaid recipients will have their hospitalization needs met. Though this court might have fashioned a different set of priorities, the best interests criteria do not transform this court into an administrative body.

III.

The final issue on appeal is whether the State was required to obtain approval from the Secretary of Health and Human Services before adopting the new changes. The parties stipulated that the reduction in hospital coverage had not been approved.

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[11] 42 U.S.C. 1396a(a)(19) provides,

(a) A State plan for medical assistance must —

• • •

(19) provide such safeguardes as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients.

The district court held that prior approval was not required. *Jennings,* 518 F.Supp. at 888. We agree.

42 U.S.C. §1396c provides that the Secretary may terminate federal funding for the Medicaid program of a state if he finds:

> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a . . .; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision.

This standard clearly contemplates the adoption of changes in the original plan without prior approval from the Secretary. However, if the changes are subsequently determined to place the State out of compliance with federal regulations, the Secretary may impose sanctions on the State's entire Medicaid program or that portion which is unsatisfactory. Only when the proposed alteration involves a change in reimbursement method is prior approval necessary. 42 U.S.C. §447.261.

As the district court noted, the states have wide latitude in the modification of their plans. Only when the plan is out of conformity with federal statutory requirements will the federal administrators intervene. While "Congress could easily have provided that no state plan could be modified without approval of the Secretary, [it] instead authorized the Secretary to invoke sanctions when modifications were found to be out of compliance with the statute." *Jennings,* 518 F. Supp. at 888.

IV.

In sum, we vacate the district court's judgment and remand for a determination in the following manner. The State should be required to provide a substantial justification for its choice of a reduction in inpatient hospital days when equal savings could be achieved by limiting the number of admissions covered by Medicaid. *Kampmeier* v. *Nyquist,* 553 F.2d 296, 299 (2d Cir. 1977) ("substantial justification" for the policy); *New York*

State Association for Retarded Children v. *Carey*, 612 F.2d at 650 ("must make at least some substantial showing in court that its plan is justified"). The State could also meet its burden by proving that a limit on the number of admissions will not yield the same amount of cost savings achieved by the State's per day restriction.[12] Second, we hold that Appellants have not established that the proposed changes are inconsistent with the best interests of Medicaid recipients. If the changes are eventually implemented, ninety five percent of the State's Medicaid recipients will be served. Though we do have some concerns about the manner in which the original changes were adopted, we cannot say that the changes were irrational or arbitrary. Finally, we hold that the State is not required to obtain approval from the Secretary of Health and Human Services before the proposed changes become final.

Accordingly, the case is remanded for further proceedings not inconsistent with this opinion.

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[12] In light of the dissent's mischaracterization of our holding in this case, we find it necessary to add the following observations. These observations should put to rest any thoughts that we are making it impossible or even difficult for Tennessee or any state to amend its Medicaid Plan.

First, contrary to the dissent's assertions, we are not making a finding of discrimination. We intimate no views on the ultimate outcome of this litigation. The dissent betrays a fundamental misunderstanding of antidiscrimination law by refusing to recognize the difference between a *prima facie* case of discrimination and an actual finding of discriminaton.

Second, contrary to the dissent's assertion, we readily acknowledge the factual distinction between this case and the relocation of the inner-city hospital in *The Medical Center*. However, the two cases warrant similar analysis. That analysis only requires the state to explain why it imposes a needless burden on groups protected by section 504.

Merritt, Circuit Judge, dissenting. Assuming *arguendo* that it is appropriate for a federal court to reach the question, I agree with the Court's holding in Part II that the state's Medicaid plan is not "contrary to the best interest" of Medicaid recipients under 42 U.S.C. §1396(a)(19) (1976). I also agree with Part III of the opinion that the adoption of the Medicaid plan in Tennessee was not procedurally deficient.

For the reasons set out below, I disagree, however, with Part I of the opinion that the state of Tennessee may not reduce its Medicaid hospitalization coverage by six days per year without violating "the general corpus of discrimination law," (Majority Opinion p.6), specifically section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794 (1976).

I.

The statute which we must interpret here, §504, provides simply that no "handicapped individual" (defined as a person "regarded" as handicapped who has an "impairment which substantially limits...major life activities") "shall, solely by reason of his handicap...be subject to discrimination" under

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Third, *Southeastern Community College* v. *Davis*, 442 U.S. 397 (1979), cited by the dissent, is simply inapplicable to the facts of this case. We agree with the dissent that if the relief sought by the appellants will require the expenditure of additional funds or impose a burden on the state, then a different case would be presented. We have reviewed the record meticulously and can discover no assertion by the State that it will have to engage in affirmative action to grant the requested relief. In fact, as noted above, the state never even considered the needs of appellants.

In sum, we take exception with the dissent's implication that we are revolutionizing the law under section 504. The dissenting opinon distills into a profound disagreement with the language of the section, and its statutory and regulatory scheme. While any analysis taken to its logical extreme would eventually lead to nihilism, requiring a state to justify what appears to be a violation of the law has not yet sent any state into chaos.

any program receiving federal funds. No further definition of "discrimination" is given.

I believe that the statute seeks only to secure for the handicapped equality of opportunity, or equality of access, in connection with government programs. It does not require a form of affirmative action or equality of results, as my colleagues insist. They hold that the plaintiffs have made a *prima facie* showing that Tennessee discriminated agains the handicapped by reducing Medicaid coverage for inpatient hospital care from twenty to fourteen days per year. They base this holding on a finding that the reduction in coverage will have a disparate impact on some classes of "handicapped" patients (e.g., asthmatic patients): a higher percentage of these classes of "handicapped" recipients will have their *health* adversely affected by the cutback than other recipients. Although budgetary constraints are the reason for the State's action — the State can no longer afford to pay for the longer period of hospitalization — the majority finds discrimination in the method the State has chosen to reduce its budget. Conceding that equality of access is present, the majority says that the state may not make a modification in its program that has a more adverse effect on the health of some group of handicapped individuals that other medical patients. The majority points to the asthmatic patient, assumes without discussion that he is a "handicapped individual" within the meaning of the statute, and finds that the state must provide him with an "equal opportunity to succeed" in achieving good health (see note 8 of the majority opinion) in comparison with other patients.

Without a clear, bright line distinction based on access, like the District Court makes, the Court's decision will create a whole new source of challenges to state budgetary decisions People with physical ailments depend on a myriad of state services more heavily than do people with no ailments. When a local government decides to reduce the quality, frequency or financing for some service, for example, bus service, some group

could make a case of discrimination, for example, by showing that they use the buses more than others. Across-the-board cuts in welfare, social security, education and many other benefits will affect some groups more than others and will open the way to litigation. I do not believe that Congress intended this statute to authorize the federal courts to step in and control the budgetary process when cuts in appropriations affect asthmatics, or some other class of patients, somewhat more heavily than another group of patients.

The substantive right or benefit in question here, according to my colleagues, seems to be good health. Since they find that the budget cut affects the health of asthmatic patients more, they find discrimination. We all want good health for ourselves and others, but there is no constitutional, statutory or other substantive legal right to good health or to equality of "success" in achieving good health through governmental programs.

The Court may be right in its speculation, although I am not convinced by its reasoning or the statistical evidence, that the handicapped as a group, however defined, will be less healthy than the non-handicapped after 14 rather than 20 days in the hospital. But the problem with this assumption, even if true, is that Medicaid does not assure better health. It grants only days of inpatient hospitalization free of charge. Medicaid only gives eligible individuals access to free hospital care for X days per year. Tennessee's decision to reduce the number of days of coverage in order to meet its budgetary requirements reduces free hospital care to the handicapped and non-handicapped equally. As District Judge Morton pointed out:

> Both handicapped and nonhandicapped Medicaid recipients will have identical hospital services available for their use, subject to the same durational limitation. The alleged problem is not with access, but with the end result... [N]either the statute nor the accompanying regulations require a program to achieve identical results for handicapped and nonhandicapped recipients.

Jennings v. *Alexander,* 518 F.Supp. 877, 883 (M.D. Tenn. 1981).

The majority relies heavily on *N.A.A.C.P.* v. *The Medical Center,* 657 F.2d 1322 (3d Cir. 1981), for the proposition that a showing of discriminatory effect establishes a *prima facie* case under Section 504. That reliance is misplaced. The case involves only the question of access to medical facilities, a point the majority does not acknowledge or discuss. The issue in the case was the effect of relocating a medical center. Assuming *arguendo* the application of a disparate impact test, the Third Circuit found that the plaintiffs failed to make a *prima facie* showing that handicapped *access* to treatment would be lessened by the proposed move. It said nothing about the effect of the new facility's services on the health of the handicapped.

A case more analogous to the one before us, discussed extensively by the District Judge, is *Doe* v. *Colautti,* 592 F.2d 704 (3d Cir. 1979). There is a mental patient challenged the Pennsylvania Medicaid law, which provided unlimited inpatient coverage for treatment in private general hospitals but limited coverage for treatment in private mental hospitals to 60 days. Doe claimed this limitation discriminates against the handicapped who are mentally ill. The court held that private mental hospitalization coverage is not required at all and, therefore, the State's decision to provide a different measure of benefits for the two types of impairment does not violate §504. It reasoned that §504 does not "obliterate the distinctions between the medical care a state medical assistance program must cover and the care it need not include." *Id.* at 710. It is this same distinction that my colleagues have "obliterated" in this case.

The recent Supreme Court case, *Southeastern Community College* v. *Davis,* 442 U.S. 397 (1979), delivers the *coup de grace* to the theory of equal treatment the majority seeks to estabish in this case. In the *Southeastern Community College* case, Justice Powell, writing for a unanimous Court, held that a state's

refusal to make modifications in its nursing education program to accommodate a deaf applicant does not violate §504. Responding to plaintiff's argument that §504 "requires Southeastern to make the kind of adjustments that would be necessary to permit her safe participation in the nursing program," the Court stated that §504 does not "compel Southeastern to undertake affirmative action." 442 U.S. 407, 409. Rather "the language and structure" of the Act "reflect a recognition by Congress of the distinction between the evenhanded treatment of qualified handicapped persons and affirmative efforts to overcome the disabilities caused by handicaps." 442 U.S. at 410.[1] It is precisely this distinction between evenhanded treatment by the state and equality of results that my colleagues fail to recognize.

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[1] The Court discussed and ruled on this distinction in the following two paragraphs:

> The language and structure of the Rehabilitation Act of 1973 reflect a recognition by Congress of the distinction between the evenhanded treatment of qualified handicapped persons and affirmative efforts to overcome the disabilities caused by handicaps. Section 501(b), governing the employment of handicapped individuals by the Federal Government, requires each federal agency to submit "an affirmative action program plan for the hiring, placement, and advancement of handicapped individuals . . ." These plans "shall include a description of the extent to which the methods whereby the special needs of handicapped employees are being met." Similarly, §503(a), governing hiring by federal contractors, requires employers to "take affirmative action to employ and advance in employment qualified handicapped individuals . . ." The President is required to promulgate regulations to enforce this section.
>
> Under §501(c) of the Act, by contrast, state agencies such as Southeastern are only "encourage[d] . . . to adopt and implement such policies and procedures." Section 504 does not refer at all to affirmative action, and except as it applies to federal employers it does not provide for implementation by administrative action. A comparison of these provisions demonstrates that Congress understood acommodation of the needs of handicapped individuals may require affirmative action and knew how to provide for it in those instances where it wished to do so.

442 U.S. 410-11.

II.

It is highly questionable whether a disparate impact test should be applied under §504. This case appears to be the first federal appellate court opinion which actually finds discrimination against the handicapped by applying a "disparate impact" test. *The Medical Center* found no *prima facie* case, even assuming the applicability of such a test. My research discloses no other appellate case that suggests that such a test is applicable under section 504, and there is now substantial doubt that the test is applicable under Title VI of the 1964 Civil Rights Act, 42 U.S.C. §2000d (1976), the provision the majority points to as the analogue for §504. *See Cannon* v. *University of Chicago,* 648 F.2d 1104, 1106-09 (7th Cir. 1981) (disproportionate impact does not establish a Title VI violation; discriminatory intent required); *Guardians Ass'n of New York* v. *Civil Service Comm'n of the City of New York,* 633 F.2d 232, 254, 272-275 (2d Cir. 1980) (same). The unsatisfactory nature of the disparate impact test is intelligently discussed in Eisenberg, *Disparate Impact,* 52 N.Y.U.L. Rev. 36 (1977), an article which proposes a better test of causation in discrimination cases.

Assuming *arguendo* the applicability of a disparate impact test, this case illustrates why such a test will not work unless a bright-line equality of access standard is used. Combining an equality of results standard with a disaprate impact test means the plaintiff always wins.

According to the majority's interpretation of the statute, a plausible interpretation in light of the broad language of the statute, there are many sub-classes of patients who fall within the "handicapped" category, not just traditional groups like the blind, the deaf and the lame. The majority's list would seem to include any serious, limiting physical or mental ailment, from asthma and arthritis to alcoholism and drug addiction. Any reduction in funding or services will have a differential impact on some class of patients. In such a situation the disparate im-

pact test will always work for some class of illness; it will always produce a finding of discrimination. The alternative solution suggested by the majority — a limitation based on the number of trips to the hospital during the year rather than the number of days — will fall hardest on the class of patients who must come often to the hospital for short stays. It is clear that the majority's alternative would also produce a finding of discrimination if its disparate impact analysis is to be carried to its logical conclusion.

There appears to be no way under the set of standards developed by the majority that a state can modify its medical program without some disparate impact on some class of patients — unless the state simply abolishes Medicaid altogether, a solution that would presumably be equal only because it denies relief to everyone. Obviously, neither the majority nor I want to encourage that kind of nihilistic solution, which requires that everyone should fail so that no one will succeed more than another — the ultimate in equality of results.

For these reasons, I respectfully but strongly disagree with the majority and would affirm the judgment of the District Court.

APPENDIX B

Rosier Jennings, et al.,

v.

Lamar Alexander, et al.,

No. 80-2043-NE-CV.

United States District Court,
M. D. Tennessee,
Northeastern Division.

June 17, 1981.

MEMORANDUM

MORTON, Chief Judge.

The plaintiffs in this case, all recipients of Medicaid benefits in Tennessee, seek to permanently enjoin the state's proposed reduction in Medicaid coverage for inpatient hospital care from the current limit of 20 days per year to a proposed maximum of 14 days per year. Although the complaint originally challenged a comprehensive array of proposed changes, and as recently as the March 13, 1981, bench trial also challenged various changes in the Medicaid drug formulary, the parties have now reached agreed settlements on all issues except the reduction in inpatient hospital coverage.

On September 3, 1980, this court preliminarily enjoined all the challenged reductions in Medicaid coverage, such injunction to remain in effect until further order of the court. The basis for that injunction was the state's failure to consult a properly constituted Medicaid Medical Care Advisory Committee prior to proposing the changes in violation of 42 U.S.C. § 1396a(a)(4) and 42 C.F.R. § 431.12. *Jennings* v. *Alexander,* No. 80-2043, Memorandum Opinion Sept. 3, 1980. It now appears that a pro-

perly constituted advisory committee has been given adequate opportunity to participate in formulating proposed changes in the Medicaid program, and therefore the reason for which the preliminary injunction was granted no longer exists. Thus, the court will examine the arguments specifically raised against the proposed reduction in coverage for inpatient hospital care to determine whether the injunction as to that proposal should be lifted, extended or made permanent.

As noted in the Memorandum Opinion of September 3, 1980, this court has subject matter jurisdiction under both 28 U.S.C. §§ 1331 and 1343. *See Hagans* v. *Lavine,* 415 U.S. 528, 94 S.Ct. 1372, 39 L.Ed.2d 577 (1974); and *Bell* v. *Hood,* 327 U.S. 678, 66 S.Ct. 773, 90 L.Ed. 939 (1946). That jurisdiction has not been challenged.

General background on the Medicaid program in Tennessee is provided in the September 3, 1980, Memorandum Opinion and is adopted herein by reference. For present purposes, it will suffice to reiterate that Medicaid is a cooperative undertaking of the federal and state governments, and that while participation by the state is voluntary, once the state decides to participate, it must do so in compliance with the requirements of Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396 *et seq.*, (hereinafter sometimes referred to as Title XIX) and the applicable federal regulations. *Harris* v. *McRae,* 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980), *reh. den.* 448 U.S. 917, 101 S.Ct. 39, 65 L.Ed.2d 1180 (1980).

The plaintiffs have raised four general arguments against the proposed reduction in hospital coverage to a maximum of 14 days per year. First, it is argued that the limitation will discriminate against handicapped Medicaid recipients in violation of section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (hereinafter "§ 504"), and the regulations promulgated thereunder. Second, the plaintiffs contend that the reduction is inconsistent with the best interests of Medicaid recipients, in violation of 42 U.S.C. § 1396a(a)(19). Third, it is argued that

any reduction in services is invalid without prior approval of the Secretary of Health and Human Services. The parties have stipulated that no such approval has been obtained. Finally, the plaintiffs contend that the injunction should remain in effect because of the state's failure to publish notice of the proposed change as required by 42 C.F.R. § 447.205. The court will address these contentions *seriatim*.

Alleged Discrimination Under § 504

The argument that the proposed reduction in inpatient hospital coverage to 14 days per year will discriminate against handicapped Medicaid recipients in violation of § 504 raises interesting questions of both law and fact. The court must first determine whether the plaintiffs have shown that the proposed limitation will have the alleged discriminatory impact if it is implemented. If the plaintiffs have met their burden of persuasion on the threshold issue of discriminatory impact, the court must then address what is apparently an issue of first impression: That is, whether a ceiling on coverage for required Medicaid services which adversely affects a greater percentage of handicapped than non-handicapped Medicaid recipients amounts to discrimination "solely by reason of . . . handicap," in violation of § 504.

Section 504 provides in relevant part as follows:

> No otherwise qualified handicapped individual . . . as defined in section 706(7) of this title, shall, *solely by reason of his handicap,* be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

29 U.S.C. § 794 (emphasis added). The relevant portion of the statutory definition of "handicapped individual" reads:

> [A]ny person who (i) has a physical or mental impairment which substantially limits one or more of such per-

son's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment.

29 U.S.C. § 706(7)(B).

Regulations duly promulgated pursuant to § 504, and specifically applicable to health, welfare and social service programs, further refine the concept of discrimination on the basis of handicap. 45 C.F.R. § 84.52(a) provides that:

> *General.* In providing health, welfare, or other social services, a recipient [of federal funds] may not, on the basis of handicap:
>
> (1) Deny a qualified handicapped person these benefits or services;
>
> (2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered nonhandicapped persons;
>
> (3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in § 84.4(b)) as the benefits or services provided to others;
>
> (4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or
>
> (5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

In order for a service to be as effective in serving the handicapped as it is in serving others, such services or benefits

> are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons lequal opportunity to obtain, or to reach the same level of achievement.

45 U.S.C. § 84.4(b)(2).

It is undisputed that the State of Tennessee is a recipient of federal funds in connection with the Medicaid program, and thus that the program is within the scope of § 504 and the regulations cited above. It is likewise undisputed that a number of recipients of Medicaid benefits in Tennessee, including certain of the named plaintiffs in this action[1] are "handicapped individuals" as that term is defined in the Rehabilitation Act, 29 U.S.C. § 706(7)(B), *supra*. Therefore, those plaintiffs have standing to challenge the proposed reduction.[2]

Evidence presented at the trial of this case established that for fiscal year 1979-80, 341,960 persons were eligible for Medicaid benefits in Tennessee. Of these, 90,668 were classified as handicapped. For the period between July 1, 1979 and June 30, 1980, 51,140 Medicaid recipients utilized one or more days of

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[1] The complaint sought class action certification as to the class of Medicaid recipients generally, as well as to various subclasses, including handicapped recipients. No hearing was held and no determination was made on the propriety of certifying any of the subclasses. Such certification would probably have been unnecessary in any event, since injunctive relief if granted would have necessarily benefitted all recipients, but in view of the court's decision to deny the § 504 claim on the merits, it is clearly not necessary to decide whether the subclass should be certified.

[2] It is generally accepted, and has not been challenged here, that § 504 creates an implied private right of action for handicapped individuals allegedly subjected to unlawful discrimination. *See Lynch* v. *Maher*, 507 F.Supp. 1268 (D.Conn. 1981); *Camenisch* v. *University of Texas*, 616 F.2d 127 (5th Cir. 1980) (*vacated and remanded on other grounds*, 449 U.S. 1075, 101 S.Ct. 853, 66 L.Ed.2d 797 (1981). *See also* cases cited in *Camenisch*, *supra*, 616 F.2d at 131, and S.Rep.No. 93-1297, 93rd Cong. 2d Sess. 39-40, *reprinted in* 4 U.S. Code Cong. & Ad.News 6373, 6391 (1974).

inpatient hospital care.[3] Of these Medicaid users of inpatient hospital care, 16,852 were handicapped and 34,288 were nonhandicapped.[4] The evidence further showed that for the fiscal year examined, 72.6% of the handicapped users would have been fully served by 14 days of hospital inpatient coverage. Stated otherwise, 27.4% of all handicapped users in 1979-80 needed more than 14 days of inpatient hospital treatment. By contrast, 92.2% of all nonhandicapped users were fully served at 14 days or less, leaving only 7.8% in need of inpatient hospital care beyond the 14th day.

Other testimony compared inpatient hospital utilization rates for handicapped and nonhandicapped users on the basis of "recipient years of eligibility" rather than the straight calculation of days of service used. The purpose of the latter calculation was to compensate for an apparent inflation of figures that results from handicapped users requiring year-round treatment, compared with others who required service only periodically. Without going into detail, suffice to say that this evidence also showed substantial disparity. For the year 1979-80, the utilization rate for handicapped was 60.1 recipients per thousand recipient years of eligibility, compared with 11.3 recipients per thousand recipient years eligibility for nonhandicapped.

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[3] There is a discrepancy of 70 recipients between two exhibits which purport to reflect total inpatient usage for the same year. Exhibit D-6c, which shows subtotals for handicapped and nonhandicapped groups, is the source of the 51,140 figure. Exhibit D-4a, broken down according to categorically needy and medically needy shows a total usage of 51,070. The court's choice of the former was based on the need to compare the handicapped and nonhandicapped, but the analysis would not be affected by a total reduction of 70 users.

[4] Thus, 18.586% of handicapped eligibles received one or more days of inpatient hospital care, as compared with 13.644% of nonhandicapped eligibles. This relatively small percentage of total persons eligible for Medicaid care constitutes the group referred to herein as "users."

The plaintiffs use these figures to argue that the proposed 14-day limitation will have a disparate impact upon handicapped Medicaid recipients. They point out that the percentage of handicapped users not fully served at day 14 was almost four times as great as the percentage of nonhandicapped users who needed more than 14 days' coverage per year. Because of this apparent disparity, the plaintiffs contend that handicapped recipients subject to a 14-day limitation would be denied access to services offered to nonhandicapped recipients, and that the inpatient services available to the handicapped would be less effective than the services available to the nonhandicapped recipients, in violation of § 504 and 45 C.F.R. § 84.52(a), *supra*. It is also argued that this reduction in services would work to impair the accomplishment of the objectives of Title XIX, as stated in 42 U.S.C. § 1396, in specific violation of 45 C.F.R. § 84.4(b)(4).[5]

The court concludes that the plaintiffs' arguments must fail for two independent but equally compelling reasons. First, the court finds that the plaintiffs have failed to carry their burden of establishing that the limitation of 14 days of hospital

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[5] 42 U.S.C. § 1396 provides, in relevant part, that the purposes of the Medicaid Act include furnishing:

> (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care....

45 C.F.R. § 84.4(b)(4) provides in relevant part:

> A recipient [of federal funds] may not ... utilize criteria or methods of administration ... (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons.

coverage will in fact have a discriminatory impact upon handicapped Medicaid recipients. Second, even if the evidence were found to establish that a disparate impact upon the handicapped as a statistical group would result from the limitation, the court would hold that such an impact is not the type of discrimination that § 504 was intended to proscribe.

From the evidence presented, there can be no doubt that if a 14-day limit on inpatient hospital coverage had been in effect in fiscal year 1979-80, the impact upon the handicapped as a statistical group would have been greater than the impact upon the nonhandicapped. However, there does not appear to be any sound basis for concluding that a similar disparity would necessarily result in another year subject to such a limitation. No evidence was offered that the ratio of handicapped to nonhandicapped inpatient hospital usage remains in any sense constant from year to year. Rather, the evidence on the issue of disparate impact consisted entirely of various analyses of statistics for a single fiscal year, and thus established no foundation for a proper extension of the figures into the future.

[1] Furthermore, the plaintiff's argument assumes that the presence of handicaps in fact accounts for the statistically higher hospital usage by the handicapped group. Such an assumption is not compelled, even for the 1979-80 year, and no evidence was offered which might convincingly warrant it.[6]

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[6] For example, there was no attempt to show what percentage of handicapped users required inpatient hospital treatment as a result of their handicapping condition. It seems likely that some handicaps, such as blindness, would rarely require hospitalization, while others, such as mental illness, might well require frequent hospitalization. Without some such evidence, the court is left to speculate on what extent the existence of handicaps in the broad sense of § 504 affects the statistical disparity shown for the study year. Indeed, the actual impact of the proposed limitation, even in the study year, should be kept in perspective. Since only 18.586% of handicapped eligibles used any inpatient hospital services, and 27.4% of those needed more than 14 days, only about 5% of the handicapped eligibles were in need of more that 14 days of hospital treatment. Thus, 95% would have been fully served at 14 days.

Thus the plaintiffs' argument requires both an assumption as to causation and an inference that the 1979-80 figures are representative of likely future hospital usage, neither of which is warranted. And the court will not base its holding on mere speculation. Therefore, the court holds that the plaintiffs have failed to establish a prima facie case that the proposed limitation on inpatient hospital coverage to 14 days per year will have a discriminatory impact upon handicapped Medicaid recipients.

Even if the disparity shown in 1979-80 were assumed to be representative of future trends in Medicaid usage, the court does not believe that a violation of § 504 would have been established. The section proscribes discrimination "solely by reason of . . . handicap." 29 U.S.C. § 794. As previously stated, the evidence in this case failed to show any causal connection between the existence of handicaps and the need for hospital care in excess of 14 days. The statistics merely revealed a correlation for the study year between handicapped users and a need for more days of hospital care than nonhandicapped users. Since there was no evidence that the presence of handicaps was the reason that the handicapped group seemed to require an average of more days of hospital care, it is difficult to conceive how the disparity could be considered discrimination "solely by reason of . . . handicap."

The plaintiffs contend that the mere existence of a disparity is sufficient to make out a prima facie case of discrimination under § 504. They argue that the section proscribes discriminatory effect, and that nothing else need be shown, citing cases in which facially neutral programs were held violative of § 504, *e.g.*, *N.A.A.C.P.* v. *Wilmington Medical Center, Inc.*, 491 F.Supp. 290 (D.Del. 1980); *Lloyd* v. *Regional Transportation Authority*, 548 F.2d 1277 (7th Cir. 1977); *New Mexico Association for Retarded Citizens* v. *State of New Mexico*, 495 F.Supp. 391 (D.N.Mex. 1980). The plaintiffs also point to 45 C.F.R. § 84.4(b)(4), *supra*, and its prohibition of "criteria or methods of administration" with the effect of discriminating

against the handicapped. Finally, reliance is placed upon the Department of Health, Education and Welfare's May 17, 1976, Statement of Policy interpreting § 504, which states:

> [h]andicapped persons may require different treatment in order to be afforded equal access to federally assisted programs and activities, and identical treatment may, in fact, constitute discrimination.

41 Fed.Reg. 20296 (May 17, 1976). Thus, the plaintiffs argue that the proposed limitation of inpatient hospital services to 14 days per year, although facially neutral, in effect discriminates against the handicapped and must be remedied by implementing some alternative criteria.[7]

The court does not believe that any of the cited authority is dispositive of the instant case. *N.A.A.C.P.* v. *Wilmington Medical Center, Inc., supra,* concerned, inter alia, allegations that the relocation of an inner-city hospital to the suburbs would disporportionately affect handicapped as well as minority persons in the service area. The court discussed the appropriate test for alleged violations of § 504 and adopted an "adverse impact" test. The court said that § 504

> requires that recipients of federal funds take affirmative action to make their programs equally accessible to the handicapped as well as forbidding them from taking actions which will have a disparate adverse effect upon the handicapped. Failure to comply with either requirement constitutes a *prima facie* violation of Section 504.

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[7] The plaintiffs ask the court to either require the continuance of the current 20-day limitation, or, if the court should determine that the present limitation also creates a disparate adverse effect, order the implementation of an alternative proposal limiting hospital stays on a per-stay basis, rather that a per-year basis. Some evidence was admitted to the effect that the latter proposal would result in reducing the cost to the state of the inpatient services, without a disparate impact upon handicapped.

491 F.Supp. at 317-18. However, the court went on to note the provisions of 45 C.F.R. § 84.4(b)(2), *supra,* to the effect that identical results are not required, and stated that as long as the handicapped were "given access to medical care equal to what afforded the general population, no discrimination will be found." *Id.*, at 318. The court then held that on the facts before it, no prima facie case had been established under § 504.

Thus, it is far from clear that the *Wilmington Medical Center* court intended to adopt as strict an "impact test" as the plaintiffs contend. Rather, it would appear that the court recognized that a program need not be equally productive for handicapped and nonhandicapped alike, as long as the program is equally accessible to both groups.

In the case at bar, the plaintiff's initial argument that the handicapped will be denied access to Medicaid inpatient hospital services if the proposed limitation is implemented, is simply untenable. Both handicapped and nonhandicapped Medicaid recipients will have identical hospital services available for their use, subject to the same durational limitation. The alleged problem is not with access, but with the end result. And, as the *Wilmington Medical Center* court recognized neither the statute nor the accompanying regulations require a program to achieve identical results for handicapped and nonhandicapped recipients.

Although *Lloyd* v. *Regional Transportation Authority, supra,* contains language indicating that a strict discriminatory impact test ought to be applied to § 504 cases, the court in that case did not apply the test, but merely vacated the district court's summary dismissal and remanded for a decision on the merits. In addition, the court's concern in *Lloyd* was clearly with the inability of mobility handicapped persons to gain access to urban transportation. As stated, *supra,* the court cannot concieve how the present case can be characterized as a denial of access to services.

Furthermore, the alleged discrimination in *Lloyd* resulted from the very existence of a particular genre of physical impairment, i.e., those conditions requiring confinement to a wheelchair, and was thus squarely within the § 504 prohibition of discrimination "solely by reason of ... handicap." In the present case, it is not a particular handicap which is allegedly subject to discrimination. Rather, the plaintiffs contend that the entire range of handicapped persons, within the broad definition of that term, 29 U.S.C. § 706(7)(B), *supra,* taken as a statistical group, are subjected to discrimination by virtue of the asserted greater need for more inpatient hospital care than other Medicaid recipients. As explained, *infra,* this court does not believe that § 504 goes that far.

New Mexico Association for Retarded Citizens v. *State of New Mexico, supra,* is arguably more helpful to the plaintiffs here. The court therein found state and local school boards in violation of §504 and the accompanying regulations for failure to provide a free appropriate public education to students suffering from mental retardation and learning disabilities. The court in that case also adopted an impact test and issued a mandatory injunction requiring affirmative action to comply with the statutory and regulatory requirements.

However, the *New Mexico* case, like *Lloyd,* involved clear discrimination on the basis of specific disabilities. In addition, the failure of the defendants in *New Mexico* to take appropriate steps to adequately educate the state's handicapped children amounted to a *de facto* denial of access to the state's public educational services. Just as persons confined to wheelchairs are denied access to city buses they are unable to mount, retarded children are denied education in a classroom where teachers and techniques are suitable only for "normal" children. The plaintiffs in *New Mexico* sought only an equal opportunity to be educated; they sought meaningful access to some education where all had been effectively denied. They did not, as the plaintiffs do here, seek additional services to ensure that they emerged from

the schools with the best education possible, or to guarantee that relatively identical percentages of handicapped and nonhandicapped children would emerge from school adequately educated. In short, the *New Mexico* plaintiffs were concerned with meaningful access; the plaintiffs here are concerned with similarity of results.

Similarly, the HEW Statement of Policy is apparently concerned with access. No indication is given that the agency ever envisioned mandating equal results for handicapped and nonhandicapped. To the contrary, 45 C.F.R. §84.4(b)(2), *supra*, squarely refutes any such intention.

In the case most closely on point to the case at bar, the plaintiffs challenged a limtation in Pennsylvania's Medicaid coverage to 60 days per year for inpatient care in a private mental institution, when no such limt existed on inpatient hospital care for physical illness. *Doe v. Colautti*, 592 F.2d 704 (3d Cir. 1979). In affirming the district court's denial of a prelimnary injunction, the court noted that care in a mental institution was an optional Medicaid service, which participating states may but need not provide, while inpatient hospital care for physical prblems is a required service. The court held that §504 could not have been intended to negate the distinction between the two types fo services which Congress had expressly allowed in the Medicaid Act, and further noted that patients with mental handicaps were allowed full treatment for physical ailments, just as nonhandicapped recipients. Thus, the court could not find the likelihood of prevailing on a §504 claim sufficient to support a preliminary injunction.

The present case can be distinguished from *Colautti* in that here the challenged limitation will affect a mandatory Medicaid service rather than an optional one. However, if the limitation is allowable under Title XIX, then the distinction becomes meaningless. The court determines that states may legitimately limit the inpatient hospital care provided under their Medicaid plans,

and further that the particular limitation proposed in this case is allowable.[8]

While some coverage for inpatient hospital care must be provided in the state's Medicaid plan, 42 U.S.C. §§1396a(a)(13) and 1396d(a), there is no requirement that Medicaid pay for all such services needed. Indeed, the specific requirement for provision of inpatient hospital services is included as part of the definition of "medical assistance," which expressly allows for "payment of *part or all* of the cost of the [required] care and services." 42 U.S.C. §1396d(a) (emphasis added). Thus, the states are allowed to set reasonable limits on the amount, scope and duration of services provided under the Medicaid program. *See Beal v. Doe*, 432 U.S. 438, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977). The court holds that a proposed limitation which, even when the evidence is considered most favorably to the plaintiffs, would fully serve at least 95% of the group allegedly most harmed by the limitation,[9] is reasonable and is allowed under Title XIX. In the absence of some indication of contrary Congressional intent, § 504 will not be read as invalidating this otherwise allowable limitation. *See Colautti, supra.*

While agreeing that a disparate impact test is the appropriate standard to apply in a §504 case, the court holds that the adverse impact arguably shown in this case does not amount to discrimination under §504. This conclusion is based upon several factors.

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[8] As explained, *infra*, the court finds that the plaintiff's argument for enjoining the reduction of benefits on the ground that it is inconsistent with the best interests of Medicaid recipients to be without merit. Similarly, the court holds that the reduction will not impair the accomplishment of the objectives of Title XIX.

[9] *See* Note 6, *supra*.

First, and most importantly,, the court is convinced that the statutory language prohibiting discrimination "solely by reason of...handicap" does not encompass the kind of disparity which the plaintiffs attempted to show in this case. Assuming, *arguendo,* that the plaintiffs had successfully established that the proposed limitation would have a disparate adverse impact upon handicapped Medicaid recipients taken as a statistical group (a question previously resolved against the plaintiffs), such an impact would not be by reason of any handicap. In reaching this conclusion, the court notes that both handicapped and nonhandicapped Medicaid recipients have full and unquestioned access to the same type and duration of inpatient treatment. Furthermore, the same durational limt works without regard to any particular handicapping condition and regardless of the particular cause of hospitalization. Indeed, it might well be assumed that of those Medicaid recipients subject to a particular handicap, some will be fully served by 14 days of inpatient care, while others will need further treatment. Coverage will be terminated under the proposed limitation when a particular recipient has exhausted the 14 days of coverage, whether the recipient is handicapped or not. The court can find no discrimination by reason of handicap.

In addition, any disparate adverse impact which the plaintiffs may have shown would be evident only in terms of the end result, and therefore under 45 C.F.R. §84.4(b)(2), *supra,* could not amount to a denial of equally effective services. THe handicapped and nonhandicapped will be afforded equal care in both quality and quantity, and the claim that fewer handicapped than nonhandicapped will be fully served does not establish a violation of §504.

Finally, although the court is persuaded that some level of a disparate impact test is the appropriate standard to apply, it is clear that not all federally funded programs which fail to serve the handicapped and nonhandicapped on an equal basis can be held in violation of §504. For example, in *Southeastern Com-*

munity College v. *Davis,* 442 U.S. 397, 99 S.Ct. 2361, 60 L.Ed.2d 980 (1979), the Court refused to find a violation of §504 where a state refused to take affirmative action to make its nursing program fully accessible to a deaf student. That case contains some rather broad language which calls into question whether affirmative action is ever required under §504. *Id.,* 442 U.S. at 411-12, 99 S.Ct. at 2369-70, 60 L.Ed.2d at 991-92.

More recently, it has been held that Department of Transportation regulations requiring affirmative action to make urban transportation systems fully accesible to mobility handicapped individuals were not within the department's authority to promulgate under §504. *American Public Transit Association* v. *Lewis* (D.C.Cir. May 26, 1981), *see* synopsis at 49 U.S.L.W. 2756. This case is important, since it provides a post-*Southeastern Community College* analysis fo the one area in which §504 had been consistently held to require affirmative action to remedy disparate impact in a facially neutral program,[10] and thus demonstrates the court's belief that the results reached in the prior cases are untenable in view of the Supreme Court's decision in *Southeastern Community College.*

These two cases alone would compel the conclusion that the kind of statistical impact asserted by the plaintiffs in the case at bar does not amount to a violation of §504. Additionally, even if some disparate impact were to have been established, the court does not believe that, under the analysis of the Court in *Southeastern Community College,* affirmative relief would be warranted.

In summary, the court holds that §504 does not require a state to structure its Medicaid program so that relatively equal per-

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[10] *See, e.g., United Handicapped Federation v. Andre,* 558 F.2d 413 (8th Cir. 1977); *Leary v. Crapsey,* 566 F.2d 863(2d Cir. 1977); *Lloyd* v. *Regional Transportation Authority,* 548 F.2d 1277 (7th Cir. 1977); *Bartels* v. *Biernat,* 427 F. Supp. 226 (E.D.Wis.1977).

centages of handicapped and nonhandicapped recipients are fully served by a particular type of benefit, as long as the benefit is equally availble to both groups. So long as a service is offered in equal quality, scope and duration to both handicapped and nonhandicapped recipients, and handicapped recipients are actually afforded equal access to that service, the mandates of §504 have been satisfied. The State of Tennessee's proposed limitation on inpatient hospital coverage to 14 days per year operates without regard to handicap, provides services that are equally available to all Medicaid recipients, and thus does not violate §504.

The "Best Interest" Requirement

The palintiffs next contend that the proposed limitation is in violation of 42 U.S.C. §1396a(a)(19), which provides as follows:

> (a) A state plan for medical assistance must —
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> ....
>
> (19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with...the best interests of the recipients.

It is argued that the best interests of the plaintiffs require that any reductions in Medicaid services be made with the least injury possible to Medicaid recipients. The plaintiffs argue that this goal can best be accomplished by implementation of a limitation based upon days per hospital stay, rather than total days per year. As noted previously, some evidence was offered that such a limitation would achieve the desired cost savings, without the asserted disparate impact upon handicapped recipients.

In support of their position, the plaintiffs rely primarily upon two cases dealing with Medicaid coverage of medically neces-

sary abortions, *Hodgson* v. *Board of County Commissioners,* 614 F.2d 829 (3rd Cir. 1980). However, neither of these cases is particularly helpful in resolving the question presently before the court. The *Hodgson* court bsaed its holding upon a finding that Minnesota's restriction on Medicaid payments for abortions to those necessary to save the life of the mother, or in cases of rape or incest, was an impermissible denial of medical care on the basis of diagnosis, type of illness or condition. 614 F.2d at 608. The best interest requirement was cited, but never expressly discussed nor relied upon.

In *Casey,* the court held that Pennsylvania's refusal to fund abortions except when necessary to save the life of the mother was in violation of the requirments of Title XIX, as modified by the "Hyde Amendment" to the 1980 Appropriation Act, P.L. 96-123, §109, 93 Stat. 926 (1979) but again failed to include any discussion of the best interest requirement. Rather, it appears that the decision of the district court in that case was again based on a finding of discrimination on the basis of diagnosis, type of illness or condition. Thus, the majority of the court of appeals panel never directly discussed the "best interest" argument. The concurring judge would have found the state statute in violation of the best interest requirement as well as the prohibition of discrimination because of type of condition. 623 F.2d at 839-40 (Hunter, J., concurring). But Judge Hunter did not offer even the slightest explanation of the appropriate standard for judging whether a state service limitation is in the best interests of Medicaid recipients, and thus his opinion provides little guidance for future application of the requirement.

The statute relied upon by plaintiffs, 42 U.S.C. §1396a(a)(19), *supra,* appears as part of the general requirements for state plans which must be approved by the Secretary of Health and Human Services prior tothe state's receipt of federal funds for the Medicaid program. *See* 42 U.S.C. §1396. The provision was included in the original version of Title XIX, as part of the 1965 amendments to the Social Security Act. The purpose of the section was stated to be:

> [To] provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibiity for medical assistance or that the states will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided.

S.Rep.No.404, 89th Cong., 1st Sess., *reprinted in* [1965] U.S. Code Cong. & Ad. News 1943, at 2017.

The present case raises the question whether the proposed limitation should be held invalid because it allegedly adversely affects the availability of inpatient hospital services to handicapped recipients, in spite of the existence of a less burdensome alternative. However, in light of the court's decision that the plaintiffs have failed to show that the limitation will have a discriminatory impact on handicapped recipients, it would be incongruous indeed to now hold that a less injurious alternative must be implemented.

The plaintiffs would have the court second-guess the decisions of the Medicaid policy makers and substitute its judgment of what would be a more desirable alternative. This the court refuses to do. The purpose of requiring state officials to consult with a Medicaid Medical Care Advisory Committee, constituted in accordance with applicable statutory and regulatory requirements, is to assure that the interests of Medicaid recipients will be taken into account in arriving at important policy and administrative decisions in regard to Medicaid. *See* Memorandum Opinion of September 3, 1980. Such consultation has apparently now been had in the present case, and absent some clear indication that the statutory guidelines have not been met, the court will defer to the policy decisions duly made.

[2] No such clear indication of statutory violation is present here. Rather, even if the court had accepted the plaintiffs' argument that the statistics on inpatient hospital usage for 1979-80

were representative of a general trend, and thus showed some likely disparate adverse impact on handicapped recipients, the evidence would still show that 95% of all handicapped recipients would be fully served with a 14-day-per-year limitation.[11] Thus the court would be constrained to hold that the evidence clearly established that the limitation was not in the best interests of recipients, especially where it is so abundantly clear, as it is here, that some cost savings measures must be taken if the Medicaid program is to continue to serve those in need. The facts of the case at bar simply do not provide a proper case for substitution of the court's judgment as to the most appropriate way to achieve the desired savings for that of the officials whose duty it is to make such decisions.[12]

Prior Approval of the Secretary of Health and Human Services

[3] The parties have stipulated that the proposal to reduce the inpatient hospital coverage from 20 to 14 days has not thus far been approved by the Secretary of Health and Human Services (HHS). Thus the court is presented with a purely legal question whether such approval is required prior to the implementation of such a change. The court concludes that prior approval is not required.

The argument advanced by the plaintiffs that prior approval is required is based upon the proposition that a state Medicaid plan must initially receive approval prior to federal funding of the state's program, 42 U.S.C. §1396, and the fact that HHS maintains oversight responsibility to assure that the state's plan remains in compliance with the statutory requirements. 42

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[11] *See* note 6, *supra*.

[12] It should be noted that the Secretary of Health and Human Services maintains continuing oversight responsibility for state plans, to ensure their continued compliance with the statutory requirements. *See* 42 U.S.C. §1396c. This oversight provides an additional safeguard that the interests of recipients will not be ignored in policy decisions.

U.S.C. §1396c; *National Welfare Rights Organization* v. *Finch*, 429 F.2d 725, 728 (D.C. Cir. 1970) (construing obligations under other titles of the Social Security Act). From these premises, the plaintiffs contend that it plainly follows that no alterations can be made in the approved state plan without prior approval.

The plaintiffs have characterized this argument as "the soul of simplicity." However, in reality it is the soul of over-simplification. Such a requirement would effectively hamstring the ability of state administrators to respond to changing demands on the Medicaid program or to respond to fiscal crises such as the one currently facing the State of Tennessee.

In addition, requiring prior approval of program changes does not square with certain express provisions of Title XIX. In relevant part, 42 U.S.C. §1396c provides as follows:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds —
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> (1) that the plan has been so changed it no longer complies with the provisions of section 1396a of this title;
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> . . .
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> . . .
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply.

This language clearly contemplates that the states do in fact have the latitude to modify their Medicaid plans, as long as such

modifications are in conformity with the statutory requirements. Congress could easily have provided that no state plan could be modified withotu prior approval of the Secretary, but instead authorized the Secretary to invoke sanctions when modifications were found to be out of compliance with the statute.

To read a requirement of prior approval into the statute would be to engage in legislation by judicial fiat, a practice this court is not wont to adopt. The result would be both to add a requirement which Congress has not seen fit to include, and to substantially obviate the need for 42 U.S.C. §1396c(1), *supra*. The court therefore holds that Title XIX does not require prior approval by the Secretary of HHS of modifications in the state Medicaid plan.[13]

Public Notice Requirements

Finally, the plaintiffs argue the the proposed reduction in inpatient hospital care must be enjoined because of the state's failure to comply with the public notice requirements of 42 C.F.R. §447.205. That regulation provides, in relevant part, as follows:

> (a) *When notice is required.* Except as specified in paragraph (b) of this section [not applicable in the case sub judice], the agency must provide public notice of any proposed change in the Statewide method or level of reimbursement for a service, if the change is expected to in-

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[13] This conclusion also appears wholly consistent with applicable regulations, which make express provision for prior approval in one situation only. Where a proposed change would alter the method of reimbursing hospitals for services provided, prior approval must be obtained. 42 C.F.R. §447.261(a). This specific provision coupled with the absence of similar regulations covering other types of changes leads to the conclusion that HHS does not view prior approval of most state plan modifications as mandatory.

crease or decrease Medicaid payments for that service by 1 percent or more during the 12 months following the effective date of the change.

. . . .

(c) *Content of notice.* The notice must —

(1) Describe the proposed change in method or level of reimbursement;

(2) Give an estimate of any expected increase or decrease in annual aggregate expenditures;

. . . .

(4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;

(5) Give an address where written comments may be sent and reviewed by the public; . . . .

Such notice is further required to be published at least 60 days before the proposed effective date of the change and appear in both a state register and the newspaper of widest circulation in each city in the state with a population of 50,000 or more. 42 C.F.R. §447.205(d).

The salient facts concerning the public notice given in the present case are not disputed. On or about June 15, 1980, notice was published in the required newspapers outlining the changes under consideration, including the possible reduction in inpatient hospital benefits. This notice stated that the Tennessee Department of Public Health (DPH) intended, on August 15, 1980, "to make some or all" of the described changes in the Medicaid program. Interested persons were invited to write to the Commissioner of Public Health if they desired to comment

on the proposals.[14] In addition, the notice stated that copies of the exact proposed changes would be made available for inspection in all county offices of the Tennessee Department of Human Services (DHS) prior to August 1, 1980 (only two weeks before the proposed effective date of the changes).

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[14] Other parts of the notice outlined changes contemplated by the Comptroller of the Treasury and directed comments to that office. These proposals are not relevant here.

The proposed changes made available in county DHS offices on or about August 1, 1980, made no mention of the plan to reduce inpatient hospital coverage to 14 days per year. To the contrary, the notice posted in county DHS offices expressly stated that "[i]n-patient hospital services . . . will be limited to twenty days per fiscal year," and continued with a proposal to generally limt weekend hospital admissions to emergency cases.

Testimony offered by the defendants at the August 16, 1980, preliminary injunction hearing established at at the time the proposals were went to DHS offices, the state had no plans to make a reduction in inpatient hospital coverage. Rather, DPH at that time intended only to implement a penalty on hospitals with low occupancy rates as an alternative way to save state money. On August 11, 1980, however, DPH was advised by the Federal Department of Health and Human Services that such a penalty could not be imposed without prior HHS approval. *See* 42 C.F.R. §447.261(a), and discussion, *supra*. DPH therefore decided to reduce the number of inpatient hospital days rather than await HHS approval of the proposed penalty.

[4] The court finds that the state has failed to comply with the public notice requirements of 42 C.F.R. §447.205 in its failure to make the proposal to reduce inpatient hospital benefits available for public review in county DHS offices. In reaching this conclusion the court need not address the questionable propriety of delaying the posting of notice in county offices until two weeks before the proposed effective date of the changes. While the regulations are silent as to the timing of this particular requirement, the practical value of complying at such a late date would be dubious, at best. In the present case, however, there was simply no compliance whatsoever. The notice finally made available in county DHS offices did not include the proposal to limit inpatient hospital coverage to 14 days per year.

the contrary, that notice was affirmatively misleading in its statement that inpatient care would be limited to 20 days per year. A concerned Medicaid recipient who had been informed by the newspaper notices that a reduction in inpatient care might be implemented and who desired to learn exactly what changes were contemplated would surely have had his fears falsely allayed by the notice posted in his local DHS office. The only effect of this misinformation would certainly have been to discourage comment on the proposal which otherwise might have been forthcoming. The tactic was in direct contravention of the policy behind the notice requirement of "foster[ing] complete information to the public as to the cost of medical care to the needy." *Philadelphia Welfare Rights Organization* v. *O'Bannon,* 501 F.Supp. 517 (E.D.Penn.1979).

The fact that the plaintiffs offered no evidence that any Medicaid recipients ever actually relied upon the posted notice or ever attempted to comment on the proposed change is irrelevant. Likewise irrelevant are the facts that the state conducted hearings which were not required by federal law at which the proposed reduction in inpatient benefits were discussed and that the proposal was included in the notice published in the Tennessee Administrative Register.

The plain truth is that federal regulations establish a particular procedure for notifying the public exactly what changes in Medicaid reimbursement procedures are being considered. This procedure includes an opportunity to inspect the text of the proposals which are to be made available in county offices throughout the state. And the simple fact is that this procedure was not complied with. The court must therefore conclude that the prelimnary injunction previously issued preventing implementation of the proposed reduction of inpatient hospital benefits must be extended pending compliance with the public notice requirement sof 42 C.F.R. §447.205.

An appropriate order will be entered.

APPENDIX C

45 C.F.R. §§ 84.1—84.5

Subpart A—General Provisions

§ 84.1 Purpose.

The purpose of this part is to effectuate section 504 of the Rehabilitation Act of 1973, which is designed to eliminate discrimination on the basis of handicap in any program or activity receiving Federal financial assistance.

§ 84.2 Application.

This part applies to each recipient of Federal financial assistance from the Department of Health and Human Services and to each program or activity that receives or benefits from such assistance.

§ 84.3 Definitions.

As used in this part, the term:

(a) "The Act" means the Rehabilitation Act of 1973, Pub. L. 93-112, as amended by the Rehabilitation Act Amendments of 1974, Pub. L. 93-516, 29 U.S.C. 794.

(b) "Section 504" means section 504 of the Act.

(c) "Education of the Handicapped Act" means that statute as amended by the Education for all Handicapped Children Act of 1975, Pub. L. 94-142, 20 U.S.C. 1401 et seq.

(d) "Department" means the Department of Health and Human Services.

(e) "Director" means the Director of the Office for Civil Rights of the Department.

(f) "Recipient" means any state or its political subdivision, any instrumentality of a state or its political subdivision, any public or private agency, institution, organization, or other entity, or any person to which Federal financial assistance is extended directly or through another recipient, including any successor, assignee, or transferee of a recipient, but excluding the ultimate beneficiary of the assistance.

(g) "Applicant for assistance" means one who submits an application, request, or plan required to be approved by a Department official or by a recipient as a condition to becoming a recipient.

(h) "Federal financial assistance" means any grant, loan, contract (other than a proccurement contract or a contract of insurance or guaranty), or any other arrangement by which the Department provides or otherwise makes available assistance in the form of:

(1) Funds;

(2) Services of Federal personnel; or

(3) Real and personal property or any interest in or use of such property, including:

(i) Transfers or leases of such property for less than fair market value or for reduced consideration; and

(ii) Proceeds from a subsequent transfer or lease of such property if the Federal share of its fair market value is not returned to the Federal Government.

(i) "Facility" means all or any portion of buildings, structures, equipment, roads, walks, parking lots, or other real or personal property or interest in such property.

(j) "Handicapped person." (1) "Handicapped persons" means any person who (i) has a physical or mental impairment which substantially limits one or more major life activities, (ii)

has a record of such an impairment, or (iii) is regarded as having such an impairment.

(2) As used in paragraph (j)(1) of this section, the phrase:

(i) "Physical or mental impairment" means (A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

(ii) "Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(iii) "Has a record of such an impairment" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

(iv) "Is regarded as having an impairment" means (A) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation; (B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or (C) has none of the impairments defined in paragraph (j)(2)(i) of this section but is treated by a recipient as having such an impairment.

(k) "Qualified handicapped person" means:

(1) With respect to employment, a handicapped person who, with reasonable accommodation, can perform the essential functions of the job in question;

(2) With respect to public preschool elementary, secondary, or adult educational services, a handicapped person (i) of an age during which nonhandicapped persons are provided such services, (ii) of any age during which it is mandatory under state-law to provide such services to handicapped persons, or (iii) to whom a state is required to provide a free appropriate public education under Section 612 of the Education of the Handicapped Act; and

(3) With respect to postsecondary and vocational education services, a handicapped person who meets the academic and technical standards requisite to admission or participation in the recipient's education program or activity;

(4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

(l) "Handicap" means any condition or characteristic that renders a person a handicapped person as defined in paragraph (j) of this section.

§ 84.4 Discrimination prohibited.

(a) *General.* No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

(b) *Discriminatory actions prohibited.* (1) A recipient, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to beneficiaries of the recipients program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

(2) For purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs.

(3) Despite the existence of separate or different programs or activities provided in accordance with this part, a recipient may not deny a qualified handicapped person the opportunity to participate in such programs or activities that are not separate or different.

(4) A recipient may not, directly or through contractual or other arrangements, utilize criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same State.

(5) In determining the site or location of a facility, an applicant for assistance or a recipient may not make selections (i) that have the effect of excluding handicapped persons from, denying them the benefits of, or otherwise subjecting them to discrimination under any program or activity that receives or benefits from Federal financial assistance or(ii) that have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the program or activity with respect to handicapped persons.

(6) As used in this section, the aid, benefit, or service provided under a program or activity receiving or benefiting from Federal financial assistance includes any aid, benefit, or service provided in or through a facility that has been constructed, expanded, altered, leased or rented, or otherwise acquired, in whole or in part, with Federal financial assistance.

(c) *Programs limited by Federal law.* The exclusion of nonhandicapped persons from the benefits of a program limited by Federal statute or executive order to handicapped persons or the exclusion of a specific class of handicapped persons from a program limited by Federal statute or executive order to a different class of handicapped persons is not prohibited by this part.

§ 84.5 Assurances required.

(a) *Assurances.* An applicant for Federal financial assistance for a program or activity to which this part applies shall submit an assurance, on a form specified by the Director, tnat the program will be operated in compliance with this part. An applicant may incorporate these assurances by reference in subsequent applications to the Department.

(b) *Duration of obligation.* (1) In the case of Federal financial assistance extended in the form of real property or to provide real property or structures on the property the assurance will obligate the recipient or, in the case of a subsequent transfer, the transferee, for the period during which the real property or structures are used for the purpose for which Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits.

(2) In the case of Federal financial assistance extended to provide personal property, the assu.ance will obligate the recipient for the period during which it retains ownership or possession of the property.

(3) In all other cases the assurance will obligate the recipient for the period during which Federal financial assistance is extended.

(c) *Covenants.* (1) Where Federal financial assistance is provided in the form of real property or interest in the property from the Department, the instrument effecting or recording this transfer shall contain a covenant running with the land to assure non-discrimination for the period during which the real property is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits.

(2) Where no transfer of property is involved but property is purchased or improved with Federal financial assistance, the recipient shall agree to include the covenant described in

paragraph (b)(2) of this section in the instrument effecting or recording any subsequent transfer of the property.

(3) Where Federal financial assistance is provided in the form of real property or interest in the property from the Department, the covenant shall also include a condition coupled with a right to be reserved by the Department to revert title to the property in the event of a breach of the covenant. If a transferee of real property proposes to mortgage or otherwise encumber the real property as security for financing construction of new, or improvement of existing, facilities on the property for the purposes for which the property was transferred, the Director may, upon request of the transferee and if necessary to accomplish such financing and upon such conditions as he or she deems appropriate, agree to forbear the exercise of such right to revert title for so long as the lien of such mortgage or other encumbrance remains effective.